



E Medicaid Forms

This section contains examples of various Alabama Medicaid forms used in documenting medical necessity and claims processing.

The following forms may be obtained by contacting the following:

Form Name	Contact	Phone
Certification and Documentation of Abortion	Community Outreach and Education	(334) 353-5203
Check Refund Form	EDS Provider Assistance Center	(800) 688-7989
Dental Prior Authorization Form	Dental Program	(334) 353-5533
Hysterectomy Consent Form	Community Outreach and Education	(334) 353-5203
Medicaid Adjustment Request Form	EDS Provider Assistance Center	(800) 688-7989
Patient Status Notification (Form 199)	EDS Provider Assistance Center	(800) 688-7989
Prior Authorization Form	EDS Provider Assistance Center	(800) 688-7989
Sterilization Consent Form	Community Outreach and Education	(334) 353-5203
Family Planning Services Consent Form	Community Outreach and Education	(334) 353-5203
Prior Authorization Request	Pharmacy Management	(334) 242-5050
Early Refill DUR Override	Pharmacy Management	(334) 242-5050
Growth Hormone For AIDS Wasting	Pharmacy Management	(334) 242-5050
Growth Hormone For Children	Pharmacy Management	(334) 242-5050
Adult Growth Hormone	Pharmacy Management	(334) 242-5050
Maximum Unit Override	Pharmacy Management	(334) 242-5050
Miscellaneous Medicaid Pharmacy PA Request Form	Pharmacy Management	(334) 242-5050
EPSDT Child Health Medical Record	Community Outreach and Education	(334) 353-5203
Alabama Medicaid Agency Referral Form	Community Outreach and Education	(334) 353-5203
Residential Treatment Facility Model Attestation Letter	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility	Institutional Services Unit	(334) 353-4945
Patient 1 st Medical Exemption Request Form	Patient 1 st Program	(334) 353-5907
Patient 1 st Complaint/Grievance Form	Patient 1 st Program	(334) 353-5907
Patient 1 st Override Request Form	Patient 1 st Program	(334) 353-5907
Request for Administrative Review of Outdated Medicaid Claim	System Support Unit	(334) 242-5501

Deleted from Certification and Documentation of Abortion, Hysterectomy Consent Form, Sterilization Consent Form, Family Planning Services Consent Form, EPSDT Child Health Medical Record, Alabama Medicaid Agency Referral Form: ~~Program Support Outreach and Education~~
Added: Community Outreach and Education

Deleted from Dental Prior Authorization Form: ~~(334) 242-5997~~
Added: (334) 353-5533

Deleted from Patient Status Notification (Form 199): ~~Long Term Care Customer Service, (800) 362-4504~~
Added: EDS Provider Assistance Center, (800) 688-7989

Deleted from Residential Treatment Facility Model Attestation Letter, Certification of Need for Services: Emergency Admission to a Residential Treatment Facility and Non-Emergency Admission to a Residential Treatment Facility: ~~(334) 242-5588~~
Added: (334) 353-4945

E.1 Certification and Documentation of Abortion

ALABAMA MEDICAID AGENCY

Certification and Documentation For Abortion

I, _____, certify that the woman, _____
_____, suffers from a physical disorder, physical injury, or physical illness,
including a life-endangering physical condition caused by or arising from the pregnancy itself that would place the woman
in danger of death unless an abortion is performed.

<i>Name of Patient</i>		<i>Patient's Medicaid Number</i>	
<i>Patient's Street Address</i>		<i>City</i>	<i>State</i> <i>Zip</i>
<i>Printed Name of Physician</i>		<i>Physician's Provider Number</i>	
<i>Signature of Physician</i>		<i>Date Physician Signed</i>	
<i>Date of Surgery</i> _____			

INSTRUCTIONS: The physician must send this form with the medical records and claim to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032

PHY-96-2 (Revised 10/01/99)
Formerly MSA-PP-81-1 Revised 10/11/96

Alabama Medicaid Agency

E.2 Check Refund Form

Mail To: EDS **Check Refund Form (REF-02)**
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Provider Name _____ Provider Number _____

Check Number _____ Check Date _____ Check Amount _____

Information needed on each claim being refunded	Claim 1	Claim 2	Claim 3
13-digit Claim Number (from EOP)			
Recipient's ID Number (from EOP)			
Recipient's name (Last, First)			
Date(s) of service on claims			
Date of Medicaid payment			
Date(s) of service being refunded			
Service being refunded			
Amount of refund			
Amount of insurance received, if applicable			
Insurance Co. name, address, and policy number, if applicable			
Reason for return (see codes listed below)			

1. BILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Med
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

Signature _____ Date _____ Telephone _____

E.3 Alabama Prior Review and Authorization Dental Request

Section I – Must be completed by a Medicaid provider. Requesting Provider License No. _____ Phone() _____ Name _____ Address _____ City/State/Zip _____ Provider Medicaid Number _____	Section II Medicaid Recipient Identification Number _____ <div style="text-align: right;">(13-digit RID number is required.)</div> Name as shown in Medicaid system _____ Address _____ City/State/Zip _____ Telephone Number _____
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Section III	DATES OF SERVICE	REQUIRED PROCEDURE CODE	QUANTITY REQUESTED	TOOTH NUMBER(S) OR AREA OF THE MOUTH
	START CCYYMMDD			
	STOP CCYYMMDD			
PLACE OF SERVICE (Circle one) 11 = DENTAL OFFICE 22 = OUTPATIENT HOSPITAL 21 = INPATIENT HOSPITAL				

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Detailed description of condition or reason for the treatment:

3. Brief Dental/Medical History: _____

NOTE :When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential." Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032



E.4 Hysterectomy Consent Form

ALABAMA MEDICAID AGENCY

HYSTERECTOMY CONSENT FORM

PART I.

PHYSICIAN

Certification by Physician Regarding Hysterectomy

I hereby certify that I have advised Field 1 Medicaid Number Field 2
 _____ to
Typed or Printed Name of Patient
 undergo a hysterectomy because of the diagnosis of Field 3 Field 4
diagnosis code
 Further, I have explained orally and in writing to this patient and/or her representative (Field 5) that she will be
Name of Representative, if any
 permanently incapable of reproducing as a result of this operation which is medically necessary. This explanation was given before the operation was
 performed.
Field 6 Field 7
Typed or Printed Name of Physician *Medicaid Provider Number*
Field 8 Field 9
Signature of Physician *Date of Signature*

PART II.

PATIENT

Acknowledgment by Patient (and/or Representative) of Receipt of Above Hysterectomy Information

I, Field 10 and/or Field 11 hereby acknowledge that
Name of Patient *Date of Birth* *Name of Representative, if any*
 I have been advised orally and in writing that a hysterectomy will render me permanently incapable of reproducing and that I have agreed to this operation.
 This oral and written explanation that the hysterectomy would make me sterile was given to me before the operation.
Field 12 Field 13
Signature of Patient *Date*
Field 14 Field 15
Signature of Representative, if any *Date*

PART III.

PHYSICIAN

Date of Surgery Field 16

PART IV.

UNUSUAL CIRCUMSTANCES

Recipient Name: _____ Recipient ID: _____

I _____ certify
Printed name of physician

- ☐ patient was already sterile when the hysterectomy was performed. Cause of sterility _____.
 Medical records are attached.
☐ hysterectomy was performed under a life threatening situation. Medical records are attached.
☐ hysterectomy was performed under a period of retroactive Medicaid eligibility. Medical records are attached.

Before the operation was performed, I informed the recipient that she would be permanently incapable of reproducing as a
 result of this operation. ☐ Yes ☐ No

Signature: _____ Date: _____

PART V.

STATE REVIEW DECISION

Signature of Reviewer: _____ Date of Review: _____ ☐ Pay ☐ Deny

Reason for denial: _____

INSTRUCTIONS: Before payment can be made for any services (physicians, hospitals, etc.) a copy of this consent form must be on file at EDS. Therefore, send this completed form to:

EDS
P.O. Box 244032
Montgomery, AL 36124-4032y

PART I.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- Record the diagnosis requiring hysterectomy
- Record the diagnosis code
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Type or print the name of the physician who will perform the hysterectomy
- Record the provider number of the physician who will perform the hysterectomy
- Physician must sign and record the date of signature. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART II.

This section is required for all routine hysterectomies. See Parts III and IV for a patient who is already sterile, a hysterectomy performed under a life-threatening emergency or during a period of retroactive Medicaid eligibility.

- Type or print the name of the patient and the patient's date of birth including the day/month/year
- Record the name of representative, if the recipient is unable to sign the consent form. If a representative is not used, record N/A in this field
- Patient must sign and record the date of signature unless a representative is being used to complete the form. Date must be the date of surgery or a prior date. If any date after surgery is recorded, the form will be denied.
- Representative must sign and record the date of signature, if the recipient is unable to sign the consent form. Date must be the date of the surgery or a prior date. If any date after surgery is recorded, the form will be denied.

PART III.

This section is required for all hysterectomies.

- Record the date of surgery once the surgery has been performed

PART IV

This section is for use when a hysterectomy was performed on a patient who was already sterile, under a life-threatening emergency in which prior acknowledgement was not possible or during a period of retroactive Medicaid eligibility. Medical records must be submitted for any hysterectomy recorded under this section. In lieu of this form, a properly executed informed consent and medical records may be submitted for these three circumstances.

- Type or print the name of the patient
- Record the recipient's 13 digit Medicaid Number
- The physician who performed the surgery must record their name
- Check the appropriate box to indicate the specific unusual circumstance
- Check the appropriate box regarding whether or not the patient was informed she would be permanently incapable of reproducing as a result of the operation.
- Attach medical records including Medical History; Operative Records; Discharge Summary and a Hospital Consent Form for the Hysterectomy.

PART V

The reviewer at the State completes this section whenever unusual circumstances are identified. EDS will send a copy of the consent form containing the State payment decision to the surgeon following State review.

E.5 Medicaid Adjustment Request Form

Mail to: Adjustments
P. O. Box 241684
Montgomery, AL 36124-1684

Section I: Provider Pay-To Information

Section II: Paid Claims Information

(Please enter data from your remittance advice)

Provider Number: _____	ICN Number: _____
Provider Name: _____	Recipient Number: _____
Address: _____	Recipient Name: _____
_____	Date(s) of Service: _____
	Billed Amount: _____
	Paid Amount: _____

Section III:

Reason for Recoupment

_____ Duplicate payment.	_____ Primary insurance payment received
_____ Claim billed in error.	_____ Provider to rebill.
_____ Recoup/delete line item _____.	_____ Medicare paid primary.
_____ Billed under wrong Recipient.	Other _____

-or-

Reason for Adjustment

_____ Change the number of units from _____ to _____ for procedure code _____.

_____ Change the procedure code from _____ to _____ on line item _____.

_____ Change the submitted charge from _____ to _____.

_____ Change _____ (place/date) of service from _____ to _____ on line item _____.

_____ Add/delete modifier on line item _____.

_____ Add/adjust primary insurance payment to _____.

_____ Adjust coinsurance/deductible from _____ to _____.

_____ Change the performing/provider number from _____ to _____.

_____ Correct the diagnosis code from _____ to _____.

_____ Re-release claim to pay at correct liability/provider rate.

Other _____

Signature _____ Date _____ Telephone# _____

E.6 Patient Status Notification (Form 199)

MEDICAID PATIENT STATUS NOTIFICATION

(To be submitted when a patient is admitted, discharged, transferred or expires)

TO: Alabama Medicaid Agency

Date: _____

P.O. Box 5624 - 36103
501 Dexter Avenue
Montgomery, Alabama 36104

FROM: _____ Provider Number: _____
(Name of Facility)

(Address of Facility) Telephone Number: _____

CURRENT PATIENT STATUS

Patient's First Name _____ M.I. _____ Patient's Last Name _____ Birthdate _____

Patient's Social Security No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Female ☐

Patient's Medicaid No: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ Male ☐

Date admitted _____ / _____
(Medicare Admission) (Medicaid Admission)

Number of Medicare Days this Admission: _____

☐ New Admission ☐ Hospital ☐ Mental Institution

☐ Re-Admission From: ☐ Home

☐ Transferred Admission ☐ Other Home _____

For Medicaid Use Only
Over 60-days late _____
Medicare Denial

Reference Information: _____
Name of Sponsor

Address of Sponsor

☐ Mental Illness ☐ Developmentally Disabled

☐ Convalescent Care ☐ Post Extended Care Days ☐ Swing Bed Approved By _____

☐ Dual Diagnosis ☐ Mental Retardation Date Approved: _____

PATIENT DISCHARGE STATUS

Discharged to: _____ Date: _____

Death (Date) _____ Signed _____

Title _____

Distribution:

White: Alabama Medicaid Agency

Blue: Office of determination for Medicaid Eligibility - Check One:

Pink: Nursing Home File Copy

☐ SSI ☐ D.O.

District Office

Form 199 (Formerly XIX - LTC - 4)
Revised 7/01/94

E.7 Alabama Prior Review and Authorization Request Form

ALABAMA PRIOR REVIEW AND AUTHORIZATION REQUEST

(Required If Medicaid Provider) PMP ()

Requesting Provider
License # or Provider # _____
Phone () _____
Name _____

Recipient Medicaid # _____
Name _____
Address _____
City/State/Zip _____
EPSDT Screening Date _____ DOB _____
Prescription Date CCYYMMDD _____

Rendering Provider Medicaid # _____
Phone () _____
Fax () _____

Name _____

Address _____
City/State/Zip _____
Ambulance Transport Code _____
Ambulance Transport Reason Code _____
DME Equipment: _____ New _____ Used

First Diagnosis _____ Second Diagnosis _____
Service Type _____ Patient Condition _____ Prognosis Code _____

(01) Medical Care	(48) Hospital Inpatient Stay*	(75) Prosthetic Device
(02) Surgical	(54) LTC Waiver	(A7) Psychiatric-Inpatient*
(12) DME-Purchase	(56) Ground Transportation	(AC) Targeted Case Management
(18) DME-Rental	(57) Air Transportation	(AD) Occupational Therapy
(35) Dental Care	(69) Maternity	(AE) Physical Therapy
(42) Home Health Care	(72) Inhalation Therapy	(AF) Speech Therapy
(44) Home Health Visits	(74) Private Duty Nursing	(AL) Vision-Optometry

DATES OF SERVICE		PLACE OF SERVICE	PROCEDURE CODE*	MODIFIER 1	UNITS	COST/ DOLLARS
Line Item	START CCYYMMDD					

Clinical Statement: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes, as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Oxygen Certifications, Home Health and Transportation) must be attached.

* If this PA is for Psychiatric or Inpatient stay, Procedure Code is not required.

Certification Statement: This is to certify that the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient and that a physician signed order is on file (if applicable). This form and any statement on my letterhead attached hereto has been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Provider _____

Date _____

FORWARD TO: EDS, P.O. Box 244032 Montgomery, Alabama 36124-4032

E.8 Sterilization Consent Form

NOTICE: YOUR DECISION AT ANY TIME TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITH HOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from (Doctor/Clinic) _____. When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks, and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the with-holding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on (Month/Day/Year) _____.

I, _____, hereby consent of my own free will to be sterilized by (Doctor) _____, by the method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about this operation to: Representative of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature) _____ (Date) _____

(Typed/Printed Name) _____

Recipient's Medicaid Number) _____

You are requested to supply the following information, but it is not required:

Race and Ethnicity Designation (please check)

_____ American Indian or Alaska Native	_____ Black (not of Hispanic origin)
_____ Hispanic	_____ White (not of Hispanic origin)
_____ Asian or Pacific Islander	

INTERPRETER'S STATEMENT

(If an interpreter is provided to assist the individual to be sterilized) I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining the consent. I have also read him/her the consent form in the _____ Language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter) _____ (Date) _____

Original – Patient

Copy 2 –EDS

Copy 3 – Patient's Permanent Record
Form 193 (Revised 8-30-02)

STATEMENT OF PERSON OBTAINING CONSENT

Before (Patient's Name) _____ signed the consent form, I explain to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Signature) _____ (Date) _____

(Title of Person Obtaining Consent) _____

(Typed/Printed Name) _____

(Facility) _____

(Address) _____

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon (Patient's Name) _____ on (Date) _____, I explained to him/her the nature of the sterilization operation (Specify Type of Operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph, which is not used.)

1. At least thirty days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed.

2. This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

_____ Premature Delivery:

Individual's expected date of delivery: _____

_____ Emergency abdominal surgery:

(Describe circumstances using an attachment)

(Signature) _____ (Date) _____

(Typed/Printed Name of Physician) _____

(Medicaid Provider Number) _____

E.9 Family Planning Services Consent Form

Name: _____

Medicaid Number: _____

Date of Birth: _____

I give my permission to _____ to provide family planning services to me. I understand that I will be given a physical exam that will include a pelvic (female) exam, Pap smear, tests for sexually transmitted diseases (STDs), tests of my blood and urine and any other tests that I might need. I have been told that birth control methods that I can pick from may include oral contraceptives (pills), Depo-Provera shots, intrauterine devices (IUDs), Norplant implant, diaphragms, foams, jellies, condoms, natural family planning or sterilization.

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

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Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

E.10 Prior Authorization Request Form

Page 1

☐ Page 1 of 1 ☐ Page 1 of 2

Medicaid Pharmacy Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36823-3210

PATIENT INFORMATION

Patient Name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

Nursing Home Resident ☐ Yes

PRESCRIBER INFORMATION

Prescribing practitioner _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____

Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Prescribing practitioner signature _____ Date _____

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ Provider # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

CLINICAL INFORMATION

Drug Requested _____ Strength _____

J Code _____ Qty. per month _____ Refills: 0 1 2 3 4 5
if applicable

Diagnosis or ICD-9 Code* _____ Diagnosis or ICD-9 Code* _____

☐ Initial Request ☐ Renewal

Medical justification _____

☐ Additional medical justification attached.

*See Instruction Sheet, Section 5

DRUG SPECIFIC INFORMATION

☐ NSAID ☐ Antihistamine ☐ H2 Antagonist ☐ PPI ☐ Antidepressants ☐ Narcotic Analgesics
☐ Platelet Aggregation Inhibitors

☐ Acute Therapy ☐ Maintenance Therapy

List previous drug usage for drug class requested

Generic/Brand/OTC _____ Reason for d/c _____

Generic/Brand/OTC _____ Reason for d/c _____

If no previous drug usage, additional medical justification must be provided.

NOTE: See Instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.state.al.us

Form 369
Revised 10/16/03

Alabama Medicaid Agency

Page 2

Patient Medicaid # _____

☐ **Sustained Release Oral Opioid Agonist**Proposed duration of therapy _____ Is medicine for PRN use? ☐ Yes ☐ NoType of pain ☐ Acute ☐ Chronic Severity of pain: ☐ Mild ☐ Moderate ☐ SevereIs there a history of substance abuse or addiction? ☐ Yes ☐ NoIf yes, is treatment plan attached? ☐ Yes ☐ No

Indicate prior and/or current analgesic therapy and alternative management choices

Drug/therapy _____ Reason for d/c _____

Drug/therapy _____ Reason for d/c _____

☐ **TNF Blocker**☐ Remicade^R ☐ EnbrelTM ☐ KineretTM ☐ HumiraTMIf Rheumatoid Arthritis, is therapy approved by a board certified Rheumatologist? ☐ Yes ☐ NoPrior and/or current DMARD therapy? ☐ Yes ☐ No If yes, attach documentation.If Crohn's disease, is therapy approved by a board certified Gastroenterologist? ☐ Yes ☐ NoIf Remicade^R is requested for Rheumatoid Arthritis, will patient be on Methotrexate? ☐ Yes ☐ No

If no, contraindication to use _____

If Psoriatic Arthritis, is therapy approved by a board certified Dermatologist? ☐ Yes ☐ No☐ **Xenical**☐ If initial request Weight _____ lbs. Height _____ inches BMI _____ kg/m²☐ If renewal request Previous weight _____ lbs. Current weight _____ lbs.Documentation MD supervised exercise/diet regimen \geq 6 mo.? ☐ Yes ☐ No Planned adjunctive therapy? ☐ Yes ☐ No☐ **Erectile Dysfunction Drugs**Gender ☐ Male ☐ FemaleAge: ☐ <18 yearsPrior drugs or devices used within past 12 months ☐ 18 years or older

1. _____ Date _____ Reason for d/c _____

2. _____ Date _____ Reason for d/c _____

Active or recent history of sexually transmitted disease? ☐ Yes ☐ No

Etiology of dysfunction confirmed by H & P

☐ Spinal cord injury ☐ Diabetic neuropathy ☐ TURP associated neuropathy (irreversible)☐ Radical prostatectomy ☐ Other (specify) _____☐ **Synagis** (Check applicable age, condition and risk factors)

Current weight _____ lbs.

☐ Gestational age \leq 28 wks & infant is < 12 months ☐ Child is < 24 months old with Chronic Lung Disease*☐ Gestational age 29-32 wks & infant is < 6 months ☐ Child is < 24 months old with Congenital Heart Disease*☐ Gestational age 33-35 wks & infant < 6 months with AAP risk factors***AND**☐ Currently outpatient with no inpatient stay in the last 2 weeks.

*Document AAP risk factor(s) and/or other required medical justification in the Drug/Clinical Information Section of this form.

☐ **Specialized Nutritionals**

Height _____ inches Current weight _____ lbs.

☐ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition☐ If \geq 21 years of age, record supports 100% of need is met by specialized nutrition

Method of administration _____ Duration _____ # of refills _____

FOR HID USE ONLY☐ Approve request☐ Deny request☐ Modify request☐ Medicaid eligibility verified

Comments _____

Reviewer's Signature _____

Response Date/Hour _____

Form 369
Revised 10/16/03

Alabama Medicaid Agency

E.11 Early Refill DUR Override Request Form

Override Request Form		
FAX: (800) 748-0116 Phone: (800) 748-0130	Fax or Mail to HEALTH INFORMATION DESIGNS	P.O. Box 3210 Auburn, AL 36832-3210
PATIENT INFORMATION		
Patient name: _____		Patient Medicaid #: _____
Patient DOB: _____		Patient phone # with area code: _____
PRESCRIBER INFORMATION		
Prescribing physician: _____		License #: _____
Address: _____		Phone # with area code: _____
City/State/Zip: _____		Fax # with area code: _____
<i>I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.</i>		
		<div style="display: flex; justify-content: space-between;"> Physician's signature _____ Date _____ </div>
PHARMACY INFORMATION		
Dispensing pharmacy: _____		Provider #: _____
NDC #: _____		J Code: _____ Qty. requested per month: _____
Phone # with area code: _____		Fax # with area code: _____
DRUG/CLINICAL INFORMATION		
<input type="checkbox"/> Early Refill <input type="checkbox"/> Maximum Unit <input type="checkbox"/> Therapeutic Duplication		
Drug name: _____		Date of last refill: _____
For Early Refill		
<input type="checkbox"/> Medication lost <input type="checkbox"/> Physician changed the dosage (documentation required below) <input type="checkbox"/> Medication destroyed <input type="checkbox"/> Medication stolen <input type="checkbox"/> Patient going out of town for period greater than the day's supply remaining of the previous refill.		
Documentation: _____		
For Maximum Unit		
Diagnosis: _____		
Medical Justification: _____		
For Therapeutic Duplication		
Indicate drugs to be discontinued		
<input type="checkbox"/> Drug name: _____		Diagnosis: _____ Stop date: _____
<input type="checkbox"/> Drug name: _____		Diagnosis: _____ Stop date: _____
		if applicable if applicable
Attach medical justification if both drugs are to be continued.		
FOR HUD USE ONLY		
<input type="checkbox"/> Approve request <input type="checkbox"/> Deny request <input type="checkbox"/> Modify request <input type="checkbox"/> Medicaid eligibility verified		
Comments _____		

Reviewer's Signature		Response Date/Hour
Form 372 Revised 11/02		Alabama Medicaid Agency

E.12 Growth Hormone for AIDS Wasting

GROWTH HORMONE FOR AIDS WASTING

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient Name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Physician's signature _____

Date _____

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ if applicable Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

☐ Initial Request ☐ Renewal (documentation attached to demonstrate effectiveness¹)

Proposed Duration of Therapy: _____ Strength/Quantity: _____ Daily Dose: _____

Height: _____ Weight: _____ BMI: _____

Diagnosis: _____ ICD-9: _____

1. Is there documentation of an unintentional weight loss and loss of muscle mass due to AIDS wasting?² ☐ Yes ☐ No
2. Is there documentation of a failed trial with appetite stimulants or weight gain agents³? ☐ Yes ☐ No
3. Has the patient been on anti-retroviral therapy for the past 120 days? ☐ Yes ☐ No
4. Has the patient been screened for intracranial malignancy or tumor? ☐ Yes ☐ No
5. If a history of malignancy exists, has the patient been free of recurrence for at least the past 6 months?
☐ Yes ☐ No ☐ No malignancy

If any of the above is answered NO, request will be denied.

6. Does the patient have any of the following contraindications? Check all that apply.

- ☐ Proliferative or preproliferative diabetic retinopathy
- ☐ Pseudotumor cerebri or benign intracranial hypertension
- ☐ Pregnancy

If any of the above contraindications apply, the request will be denied.

¹ Weight stabilization or weight gain must be reported to continue therapy.

² There must be an unintentional weight loss of 10% over 12 months or 7.5% over 6 months or BMI < 20 kg/m².

³ Drugs to stimulate appetite and/or promote weight gain, such as Perlaactin®, Marino®, Megace®, Oxandrin®, or androgenic steroids.

FOR HID USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments: _____

Reviewer's Signature _____

Form 366
Revised 5/16/03

Response Date/Hour _____

Alabama Medicaid Agency

E.13 Growth Hormone for Children Request Form

GROWTH HORMONE¹ FOR CHILDREN

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116

Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210

Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:☐ Documented growth hormone deficiency ☐ Turner Syndrome ☐ Growth Deficiency due to Chronic Renal Insufficiency**Diagnostic testing required:**1. Growth Hormone Deficiency²: Confirmed with provocative testing and IGF-1 levels: IGF-1 Level: _____ Date: _____

Provocative Testing: Test 1: type: _____ Result: _____ Date: _____

Test 2: type: _____ Result: _____ Date: _____

2. Turner Syndrome³: Karyotyping: Date: _____ Results: _____3. Chronic Renal Insufficiency: Is the patient currently receiving dialysis? ☐ Yes ☐ No (If no, request will be denied)

IGF-1 Level: _____ Date: _____

4. Is patient's thyroid function normal ☐ Yes ☐ No5. Is patient's height less than 5th percentile? ☐ Yes ☐ No6. Has the patient been screened for intracranial malignancy or tumor⁴? ☐ Yes ☐ No (If no, request will be denied)

7. If a history of malignancy exists, has patient been free of recurrence for at least the past 6 months?

☐ Yes ☐ No (If no, request will be denied) ☐ No malignancy

8. Does the patient have any of the following contraindications? Check all that apply.

☐ Pregnancy ☐ Proliferative or preproliferative diabetic retinopathy ☐ Pseudotumor cerebri or benign intracranial HTN☐ Closed epiphyses (After epiphyseal closure use Adult Growth Hormone Therapy criteria.)¹Nutropin AQ[®], Nutropin[®], Humatrope[®], Genotropin[®], and Protropin[®]

²As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. ITT is contraindicated in patients with seizures, CAD, abnormal EKG with history of IHD or CVD. If ITT is contraindicated, documentation must be provided and an alternative test performed. Results from other stimulation tests (arginine, glucagon, L-dopa, growth hormone-releasing hormone [GHRH], and combinations of these agents, excluding clonidine), may be submitted for those patients with documented contraindication to ITT. GH peak levels of ≤ 10 ng/ml after provocative testing support GH deficiency and justify treatment. For patients with CRI on dialysis, only an IGF-1 level is required.

³Short stature in girls with Turner Syndrome is not due to GH deficiency, but growth failure due to an intrinsic skeletal dysplasia. The decision to treat these patients is not based on provocative testing but on the diagnosis of Turner Syndrome using karyotyping.

⁴Children being considered for treatment with growth hormone must be screened prior to initiation of therapy to verify the absence of any malignant condition. If growth failure results from an intracranial tumor, absence of tumor growth or tumor recurrence must be documented for at least 6 months before initiating growth hormone therapy.

FOR HIC USE ONLY

☐ Approve request☐ Deny request☐ Modify request☐ Medicaid eligibility verified

Comments: _____

Reviewer's Signature _____

Response Date/Hour _____

Form 410
Revised 1/23/03

Alabama Medicaid Agency

E.14 Adult Growth Hormone Request Form

ADULT GROWTH HORMONE¹

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Physician's signature _____

Date _____

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

☐ Initial request ☐ Renewal Drug requested: _____ Proposed duration of therapy: _____

Strength/Quantity: _____ Daily dose: _____ Height: _____ Weight: _____

Patient must have one of the following primary indications listed below, confirmed by a board certified endocrinologist:

- ☐ Adult with childhood onset of growth hormone deficiency
- ☐ Adult onset of growth hormone deficiency with no other deficiencies
- ☐ Adult onset of growth hormone deficiency without other pituitary hormone deficiencies

Diagnostic testing required:

1. IGF-1 Level: _____ ng/ml Date: _____

2. Is there a contraindication to ITT²? ☐ Yes ☐ No

If yes, indicate reason: _____

3. Provocative Testing: Check appropriate selection

☐ Adult with childhood onset GHD or with additional pituitary hormone deficits (one {1} stimulation test required)

☐ Adult with suspected GHD with no other pituitary hormone deficits (two {2} stimulation tests required)

Test 1: type _____ Results: _____ ng/ml Date: _____

Test 2: type _____ Results: _____ ng/ml Date: _____

4. Has the patient been screened for intracranial malignancy or tumor? ☐ Yes ☐ No (If no, request will be denied)

5. If a history of malignancy exists, have they been free of recurrence for at least the past six (6) months?

☐ Yes ☐ No (If no, request will be denied) ☐ No malignancy

6. Does the patient have any of the following contraindications? Check all that apply. **If any apply, deny request. If not, approve.**

☐ Pregnancy ☐ Proliferative or preproliferative diabetic retinopathy ☐ Pseudotumor cerebri or benign intracranial HTS

¹Nutropin A.Q®, Nutropin®, Humatrope®, Genotropin®, and Protropin®

²As provocative testing, Insulin Tolerance Test is **required** unless contraindicated. If contraindicated (seizures, CAD, abnormal EKG with history of IHD or CVD, and not advised for those > age 60), documentation must be provided and an alternative test result (arginine, glucagon, growth hormone-releasing hormone (GHRH), L-dopa and combinations of these agents, excluding clonidine) may be substituted.

FOR HID USE ONLY

☐ Approve request

☐ Deny request

☐ Modify request

☐ Medicaid eligibility verified

Comments: _____

Reviewer's Signature
Form 411
Revised 12/05/02

Response Date/Hour

Alabama Medicaid Agency

E.15 Maximum Unit Override

FAX OR MAIL TO:
ALABAMA QUALITY ASSURANCE FOUNDATION
PHARMACY ADMINISTRATIVE SERVICES
One Perimeter Park South, Suite 200 North, Birmingham, AL 35243-2354
Phone: (888) 633-2243 Fax: (888) 329-6759 or (205) 977-4215

Requester: _____

Name and title (MD, RN, RPh)

PATIENT INFORMATION

Patient's Name: _____ Patient's Medicaid #: _____

Diagnosis: _____ Patient's DOB: _____

PRESCRIBER INFORMATION

Prescribing Physician: _____ License Number: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Fax #: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. This is an initial certification.

 Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider Number: _____

NDC #: _____

Phone #: _____ Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name: _____ Quantity/month: _____

Diagnosis: _____

Medical Justification: _____

***Supporting documentation should be available in the patient record.

FOR AQAF USE ONLY

_____ Approve request _____ Deny request _____ MEDICAID ELIGIBILITY VERIFIED

Authorization effective _____ through _____ Deny/Request Additional Information

Authorization #: _____

 Reviewer's Signature

 Response Date/Hour

E.16 Miscellaneous Medicaid Pharmacy PA Request Form

MISCELLANEOUS DRUGS

PRIOR AUTHORIZATION REQUEST FORM

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient name: _____ Patient Medicaid #: _____

Patient DOB: _____ Patient phone # with area code: _____

PRESCRIBER INFORMATION

Prescribing physician: _____ License #: _____

Address: _____ Phone # with area code: _____

City/State/Zip: _____ Fax # with area code: _____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Physician's signature Date

PHARMACY INFORMATION

Dispensing pharmacy: _____ Provider #: _____

NDC #: _____ J Code: _____ Qty. requested per month: _____

Phone # with area code: _____ Fax # with area code: _____

DRUG/CLINICAL INFORMATION

Drug requested: _____ Quantity requested: _____

Number of refills requested: _____ Diagnosis: _____

Explanation of medical necessity: _____

FOR HID USE ONLY

☐ Approve request

☐ Deny request

☐ Modify request

☐ Medicaid eligibility verified

Comments: _____

Reviewer's Signature

Response Date/Hour

Form 365
Revised 9/19/02

Alabama Medicaid Agency

E.17 EPSDT Child Health Medical Record (4 pages)

EPSDT CHILD HEALTH MEDICAL RECORD

Name _____ Medicaid Number _____
 Last First Middle

Sex _____ Race _____ Birth Date _____
 M _____ White _____ Black _____ Am. Indian _____
 F _____ Latino _____ Asian _____ Other _____

I give permission for the child whose name is on this record to receive services in the _____
 I understand that he/she will receive tests, immunizations, and exams. I understand that I will
 be expected to follow plans that are mutually agreed upon between the health staff and me.

Date _____ Relationship _____	Date _____ Relationship _____
Signature _____	Signature _____
Date _____ Relationship _____	Date _____ Relationship _____
Signature _____	Signature _____
Date _____ Relationship _____	Date _____ Relationship _____
Signature _____	Signature _____
Date _____ Relationship _____	Date _____ Relationship _____
Signature _____	Signature _____

FAMILY HISTORY

(Code Member Having Disease)

(F-Father, M-Mother, S-Sibling, GP-Grandparent, O-Other)

If Negative, place an N in the blank

_____ heart disease	_____ high blood pressure	_____ tuberculosis	_____ cancer
_____ stroke	_____ blood problem/disease	_____ birth defects	_____ stroke
_____ asthma	_____ nerve/mental problem	_____ mental retardation	_____ diabetes
_____ alcohol/drug abuse	_____ foster care	_____ Other	

Update (annually) _____	Update (annually) _____
Update (annually) _____	Update (annually) _____
Update (annually) _____	Update (annually) _____
Update (annually) _____	Update (annually) _____

MEDICAL HISTORY

HISTORY	0-Neg +-Pos	DETAIL POSITIVES	HISTORY	0-Neg +-Pos	DETAIL POSITIVES
Childhood Diseases			Frequent Colds		
Diabetes Mellitus			Tonsillitis		
Epilepsy			Bronchitis		
Thyroid Dysfunction			Ear Infection		
Mental Illness			Pneumonia		
Rheumatic Fever			Convulsions		
Heart Disease			Headache		
Hepatitis			Drug Sensitivity		
Blood Dyscrasia			Allergies		
Anemia			Medications		
Eczema			Operation, Accident		
Tuberculosis			Drug Abuse		
Asthma			Chronic Problems		

Hospitalizations (year & reason) _____

Updates (each screening) _____

Form 172
 Revised 1/1/97

Alabama Medicaid Agency

DEVELOPMENTAL ASSESSMENT

DATE	NORMAL	ABNORMAL (detail)	DATE	NORMAL	ABNORMAL (detail)

ANTICIPATORY GUIDANCE

(Should be done at each screening and documented with a date)

2 Weeks to 3 Months <small>Dates completed</small> _____ Nutrition Safety Spitting up, hiccoughs, sneezing, etc. Immunizations Need for affection Skin & scalp care, bathing frequency Teach how to use the thermometer and when to call the doctor	13 to 18 Months <small>Dates completed</small> _____ Nutrition Safety Dental hygiene Temper tantrums Obedience Speech development Lead poisoning Toilet training counseling begins	6 to 13 Years <small>Dates completed</small> _____ Nutrition Safety (auto passenger safety) Dental care School readiness Onset of sexual awareness Peer relationships (male & female) Parent-child relationships Prepubertal body changes (menst.) Alcohol, drugs and smoking Contraceptive information if sexually active
4 to 6 Months <small>Dates Completed</small> _____ Nutrition Safety Teething & drooling/dental hygiene Fear of strangers Lead poisoning	19 to 24 Months <small>Dates Completed</small> _____ Nutrition Safety Need for peer relationships Sharing Toilet training should be in progress Dental hygiene Need for affection and patience Lead poisoning	14 to 21 Years <small>Dates completed</small> _____ Nutrition/dental Safety (automobile) Understanding body anatomy Male-female relationships Contraceptive information Obedience and discipline Parent-child relationships Alcohol, drugs and smoking Occupational guidance Substance abuse
7 to 12 Months <small>Dates completed</small> _____ Nutrition Safety Dental hygiene Night crying Separation anxiety Need for affection Discipline Lead poisoning	3 to 5 Years <small>Dates completed</small> _____ Nutrition Safety Dental hygiene Assertion of independence Need for attention Manners Lead poisoning Alcohol & drugs	

NUTRITIONAL ASSESSMENT

DATE	ADEQUATE	INADEQUATE (detail)	DATE	ADEQUATE	INADEQUATE (detail)

PHYSICAL ASSESSMENT

(UC=Under the care)

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ____ *UC ____		Referral ____ UC ____		Referral ____ UC ____		Referral ____ UC ____	
Physical Examination		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:	
Signature									

PHYSICAL ASSESSMENT

Date of Exam									
Age	School Grade								
Height	Weight								
Head Circumference									
Temperature									
Pulse	Blood Pressure								
Hearing		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Vision		(R)	(L)	(R)	(L)	(R)	(L)	(R)	(L)
Dental Care		Referral ____ UC ____		Referral ____ UC ____		Referral ____ UC ____		Referral ____ UC ____	
Physical Examination		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:		WNL <input type="checkbox"/> Abnormal:	
Signature									

Replaced form

E.18 Alabama Medicaid Agency Referral Form

ALABAMA MEDICAID REFERRAL FORM			
PHI-CONFIDENTIAL			
Today's Date _____		Date Referral Begins _____	
Important NPI Information See Instructions			
MEDICAID RECIPIENT INFORMATION			
Recipient Name _____		Recipient # _____	Recipient DOB _____
Address _____		Telephone # with Area Code _____	
		Name of Parent/Guardian _____	
PRIMARY PHYSICIAN (PMP)		SCREENING PROVIDER IF DIFFERENT FROM PRIMARY PHYSICIAN (PMP)	
Name _____		Name _____	
Address _____		Address _____	
Telephone # with Area Code _____		Telephone # with Area Code _____	
Fax # with Area Code _____		Fax # with Area Code _____	
Email _____		Email _____	
Provider # _____		Provider # _____	
Provider NPI # _____		Provider NPI # _____	
Signature _____		Signature _____	
TYPE OF REFERRAL			
<input type="checkbox"/> Patient 1 st <input type="checkbox"/> EPSDT Screening Date _____ <input type="checkbox"/> Case Management/Care Coordination		<input type="checkbox"/> Lock-in <input type="checkbox"/> Patient 1 st /EPSDT Screening Date _____ <input type="checkbox"/> Other	
LENGTH OF REFERRAL			
Referral Valid for _____ month(s) or _____ visit(s) from date referral begins.			
REFERRAL VALID FOR			
<input type="checkbox"/> Evaluation Only <input type="checkbox"/> Evaluation and Treatment <input type="checkbox"/> Referral by consultant to other provider for identified condition (cascading referral) <input type="checkbox"/> Referral by consultant to other provider for additional conditions diagnosed by consultant (cascading referral)		<input type="checkbox"/> Treatment Only <input type="checkbox"/> Hospital Care (Outpatient) <input type="checkbox"/> Performance of Interperiodic Screening (if necessary)	
Reason for Referral By Primary Physician (PMP)		Other Conditions/Diagnoses Identified by Primary Physician (PMP)	
CONSULTANT INFORMATION			
Consultant Name _____			
Address _____		Consultant Telephone # with Area Code _____	
<small>Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician (PMP).</small>			
Findings should be submitted to primary physician (PMP) by			
<input type="checkbox"/> Mail <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> In addition, please telephone			
Form 362 Rev. 10-23-06		Alabama Medicaid Agency www.medicaid.alabama.gov	

Please find below information regarding the Medicaid Referral Form that was revised on 10/23/06. This information is being provided so that providers have a reference tool when utilizing this form. Questions regarding policy should be referred to the Patient 1st program at (334) 242-5148. Should you need an inservice for your staff on the form, you may contact the Outreach and Education Unit at (334) 353-5203.

General Information

Maintenance of Original Documentation:

1. The PMP should maintain the “original” referral form. Therefore, it is ok for consulting providers to receive copies, faxes or e-mailed versions of the referral form.
2. If the PMP completes, it will have his original signature and the PMP will copy and forward as necessary.
3. If the PMP has an MOU or a contract with someone else to complete the referral form, the PMP will receive a copy of the form from that person and the PMP should initial approval and keep in his/her file and this will become the “original”.
4. If the PMP has an outside person performing the screening - the screener will complete their part of the form, sign, and keep this original for their file and forward a copy to the PMP. The PMP will then sign the copy and keep as his original. Therefore, each provider (PMP and screener) will have an original. But, if the referral needs to be forwarded on, a copy with the PMP's signature should be the one to send.

Memorandum of Understanding (MOU)

1. If the PMP has another physician take call for him and they have the understanding that it is ok to use the PMP's referral number, then the covering physician will not have to obtain a written referral. However, if the recipient needs to receive other care from a different provider, the consulting provider will need a written referral from the PMP. If the covering physician has approval from the PMP, the covering physician can sign the referral form on behalf of the PMP.
2. When operating under an MOU, each party must clearly understand what the agreement is so there is not a misunderstanding when it comes time to bill for the services. These parties need to have an agreement/contract in writing.

Completion Instructions

Today's Date – the date the form is completed and signed.

Referral Date – the date the referral is effective. This **is not a required field** but is appropriate to be used when the referral is/was needed for date other than today's date.

Recipient Information – enter recipient demographic information.

Primary Physician – the PMP in most cases. If for a lock-in recipient, it will be for the physician they are assigned to. **Primary Physician Signature:** It is ok to have a stamped signature with initials. It is ok to have someone else sign on behalf of the PMP as long as they have the PMP permission/MOU (memorandum of understanding) and it is indicated on the referral form. If case managers/care coordinators have an agreement with the PMP and are filling out the form for the PMP they should indicate “Signature On File/MOU”. On forms that are sent via e-mail the PMP will indicate signature on file.

Note: *The provider number is the number the recipient is assigned to (if a clinic, it will be the clinic number).*

Screening Provider – to be completed only if the person performing a screening is not the PMP or if it is for a child who **is not enrolled in** the Patient 1st program. **Note: The provider number in this situation is the screening provider number.**

NPI Information – Referrals that will be effective beyond May 2007 will need to have both the NPI and provider numbers. This will enable specialty providers to have the necessary information to receive payment once NPI changes are implemented. Providers receiving referrals SHOULD NOT BEGIN TO USE THE NPI number until advised to do so by Medicaid and EDS.

Type of Referral

Patient 1st – is for a referral that is Patient 1st only (not an EPSDT).

Lock-in – is for a referral for a recipient that is locked into one physician/pharmacy and must have referral for other services.

EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is not enrolled in the Patient 1st program. Date of screening (which is the date the actual screening was performed) needs to be written here. **This is a mandatory field.**

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Patient 1st/EPSDT – is for a referral resulting from an EPSDT screening of a recipient who is enrolled in the Pt.1st program. Indicate date of the screening (**this is a mandatory field**).

Note: The same screening date should be used for all services provided as the result of the screening – there cannot be retro dates. Also, the referral date may be different from the date of the screening.

Case Management/Care Coordination – is for a referral to a case manager of the Targeted Case Management Program for the medically at risk. To be used in order for the recipient to receive case management services.

Note: It is possible for more than one referral to be checked - i.e. Patient 1st and Case Management/Care Coordination

Length of Referral – is the amount of time the referral is good for from the referral date. **This is a mandatory field and must be completed in order for the referral to be valid.** How this section is completed is up to the physician completing the form. In some situations it may be more appropriate to utilize a specific number of visits if the physician knows how many it would take to resolve the problem or if it is for a one-time consultation he/she would indicate one visit. If it is for a condition that may take several months to resolve and it is not known how many visits are needed, then the PMP may prefer to indicate months.

Note: If the referral is to be used for more than one type of referral and the physician wishes the number of visits to be different, then a separate form should be filled out for each type of referral.

Referral Valid For (Check all that apply):

Evaluation only – this would be used in a situation where the physician is sending the recipient for a consultation and wants an evaluation or input on how to formulate the treatment plan.

Example: A physician who has a recipient with diabetes who is not responding to treatment would be referred to an endocrinologist to determine the best type of Insulin to use.

Evaluation and Treatment – this would be used in a situation where the physician determines the recipient's condition could be better treated by another physician. *Example:* A recipient with cancer would be referred to an oncologist for evaluation and chemotherapy.

Referral by consultant to other provider for identified condition – this would be used in a situation where the physician thinks more than one consultant may be needed to provide treatment for the identified condition. It gives permission to the consultant to refer on to another consultant for the identified diagnosis listed on the referral form without having to call the PMP for another referral. *Example:* Recipient who has been involved in a car wreck and may need care by a cardiologist, an orthopedic, a plastic surgeon, etc.

Referral by consultant to other provider for additional conditions diagnosed by consultant (Cascading Referral) – this would be used in the situation where the physician thinks that there may be more than one problem and would like for the consultant to refer the recipient as necessary without having to contact the PMP for permission. *Example:* A recipient who is referred to a cardiologist for chest pain and it is discovered that the recipient has gallstones.

Treatment Only – this is to be used in a situation where the physician has made the diagnosis but needs treatment to be provided elsewhere. *Example:* A recipient with a back injury who needs physical therapy.

Hospital Care (outpatient) – this would be used in a situation where the recipient needs care provided in the outpatient setting. *Example:* Non-emergency care provided in the emergency room, therapies performed as an outpatient, or care provided through ambulatory surgical centers.

Performance of Interperiodic screening (for children under age 21) if necessary – to be used in the situation where the physician thinks the recipient may have a condition that has not previously been identified or a condition that has changed significantly that may require continued care or follow-up. *Example:* a recipient who is referred to a pulmonologist for respiratory problems and is suspected to have asthma.

Note: Do not perform a screening unless this checked.

Note: If a recipient is in the hospital and you know that care will be needed outside the hospital please obtain a referral for any follow-up services that will be needed.

Reason for referral by Primary Physician/Other Conditions and Diagnoses Identified by Primary Physician – the physician should indicate the reason the recipient is being referred. The physician should also list any other conditions that the recipient currently has that might affect or be affected by treatment. *Example:* A recipient who is being referred for treatment of asthma also has diabetes. It is very important to know that because some of the drugs used for treating asthma can affect blood sugars significantly and if it is not known that the recipient has diabetes, the recipient could have severe adverse reactions.

Consultant information – indicate the name of the provider the recipient is being referred to. If the recipient is to be referred to more than one consultant, they may be listed in other available spaces on the form or listed on another page. The consultant may also indicate in his findings that the recipient is being referred on to another consultant.

Written report – findings of the consultation should be sent to the primary physician unless the physician has an agreement with the EPSDT screener to do the follow-up. The findings should be reported within 30 days.

Submit findings by – the primary physician should indicate whether he wants to be called with the findings, have them mailed, emailed or faxed.

E.19 Residential Treatment Facility Model Attestation Letter

Residential Treatment Facility Model Attestation Letter

(RTF LETTERHEAD)
NAME OF THE RTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER
PROVIDER NUMBER (IF APPLICABLE)

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (Psych Under 21 rule).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the Psych Under 21 rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the Psych Under 21 rule.

Signature,

Printed Name

Title

Date

***This attestation must be signed by an individual who has the legal authority to
obligate the facility.***

Revised 10/01/01

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov.

E.20 Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

Certification of Need for Services: Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 who are admitted to an Alabama residential treatment facility (RTF) on an emergency basis or for individuals who become eligible for Medicaid after admission to the RTF. The interdisciplinary team shall complete and sign this form within 14 days of the emergency admission. This form shall be completed on or before the date of the application for Medicaid coverage for individuals who become eligible after admission. This form shall be filed in the recipient's medical record upon completion to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name

Recipient Medicaid Number

Date of Birth

Race

Sex

County of Residence

Facility Name and Address

Admission Date

INTERDISCIPLINARY TEAM CERTIFICATION:

1. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.
2. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.
3. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.

Printed Name of Physician Team Member

Signature

Date

Printed Name of Other Team Member

Signature

Date

Printed Name of Other Team Member

Signature

Date

Form 371

Revised 10/01/01

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.21 Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

Certification of Need for Services: Non-Emergency Admission to a Residential Treatment Facility

This form is required for Medicaid recipients under age 21 seeking non-emergency admission to an Alabama residential treatment facility (RTF). The independent team shall complete and sign this form not more than 30 days prior to admission. This form shall be filed in the recipient's medical record upon admission to verify compliance with the requirements in the Medicaid Administrative Code Rule 560-X-41-.13.

Recipient Name

Recipient Medicaid Number

Date of Birth

Race

Sex

County of Residence

Facility Name and Address

Planned Admission Date

PHYSICIAN CERTIFICATION:

- 1. I am not employed or reimbursed by the facility.**
- 2. I have competence in diagnosis and treatment of mental illness.**
- 3. I have knowledge of the patient's situation.**
- 4. Ambulatory care resources available in the community do not meet the treatment needs of this recipient.**
- 5. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician.**
- 6. The services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed.**

Printed Name of Physician

Physician Signature

Phone Number Date

Physician Address

License Number

Printed Name of Other Team Member

Signature

Phone Number Date

Printed Name of Other Team Member

Signature

Phone Number Date

Form 370

Revised 10/01/01

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov

E.22 Patient 1st Medical Exemption Request Form

The Patient 1st Program is based on the premise that patient care is best served by a medical home where a Primary Medical Provider (PMP) may coordinate care. The purpose of this form is for the provider to list the reasons why a patient would not benefit from this system of care.

(Recipient's Name)

(Medicaid Number)

(Date of Birth)

Attention Physician: This section is to be completed only by the physician. Please check all blocks that apply regarding the patient's medical condition, and mail to the address below. (**Note:** At least one block should be checked, and the physician information requested below completed.)

- ☐ **Terminal Illness** (**Note:** The enrollee has a six month or less life expectancy and/or is currently a hospice patient.)
- ☐ **Impaired Mental Condition** which makes it impossible for the adult enrollee to understand and participate in Patient 1st. (**Note:** This statement is not a determination of the patient's legal mental competence.)
- ☐ Currently undergoing **Chemotherapy** or **Radiation treatments**. (**Note:** Exemption for this is temporary and will end with the completion of the therapy).
- ☐ **Diagnosis/Other information:** (Specify reasons why this recipient would not benefit from having a medical home with a local PMP who would coordinate his/her care.)
- _____
- _____
- _____

Print Physician's Name

(Medicaid Provider/NPI Number)

Telephone Number

Return Mailing Address

City

State

Zip

Physician's Signature

Date

If you have any questions or would like to apply to become a Patient 1st provider, please contact the Patient 1st Program at (334) 242-5148. Send this completed and signed form via Fax to (334)353-3856 or mail to:

**Alabama Medicaid Agency
Patient 1st Program
501 Dexter Avenue
Montgomery, AL 36103**

Form 392

Revised 2/13/07

Alabama Medicaid Agency
www.medicaid.alabama.gov

Added: Print
Physician's
Name

Deleted:
(Physician
Signature)
Added: NPI,
Telephone
Number

Deleted:
(Date)
Added:
Return
Mailing
Address,
City, State,
Zip.

Physician's
Signature
Deleted:
(Print
Physician
Name),
(Telephone
Number)

Added: Date,
Revised
2/13/07,
www.medicaid.alabama.gov

**Note: for reporting complaints regarding Patient 1st Providers Only*

Name of Person Completing this Form: _____
(May be the recipient, designated friend/family member, medical provider, hospital, community member, etc.)

Name of Doctor: _____ Practice: _____

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There are no margins, text, or other markings on the paper.

Alabama Medicaid Agency

PATIENT 1ST COMPLAINT/GRIEVANCE FORM

Patient 1st staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place to address them. It is not necessary to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint. **PLEASE DO NOT SIGN BOTH STATEMENTS.**

1. If you agree to allow us to use your name in investigating this complaint, please sign the following:

I give the Patient 1st staff permission to use my name when sharing my complaint with the Primary Medical Provider (PMP) named in my complaint. The PMP has my permission to respond to the Patient 1st staff concerning my complaint and release medical records regarding the patient when necessary.

Signature of Complainant

Date

Signature of Patient/Parent/Legal Guardian

Complainant's Date of Birth

OR

2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:

Signature of Complainant

Date

Signature of Patient/Parent/Legal Guardian

Complainant's Date of Birth

If you have any questions regarding the use of this form or the Patient 1st complaint process, please contact the Patient 1st Program in Montgomery at 334-353-5907. *Thank you for giving us this opportunity to serve you better.*

Please Do Not Write Below This Line

Patient 1st PMP Name: _____ PMP#

Patient 1st Practice Name:

County Where Patient 1st Practice is Located:

Comments:

Form 393
Agency

Alabama Medicaid

E.24 PATIENT 1ST Override Request Form

Complete this form to request a Patient 1st override when you have received a denial for referral services **or** the Primary Medical Provider (PMP) has refused to authorize treatment for **past** date(s) of service. The request must be submitted to Medicaid's System Support Unit within 45 days of the date of service. Overrides will not be considered unless the PMP has been **contacted and refused** to authorize treatment. Attach a "clean claim" with any supporting documentation to this form and mail to System Support at the address below. System Support will process your request within 30 days of receipt. If your request is approved, the corrected claim will be sent to EDS and will be processed. If your request is denied, System Support will notify you by mail of the denial. This form is available in Appendix E of the Alabama Medicaid Provider Manual and at www.medicaid.alabama.gov.

Mail To:
Alabama Medicaid Agency
System Support
501 Dexter Avenue
Montgomery, AL 36103

Recipient's Name: _____ Medicaid Number: _____

Date(s) of Service: _____

Name of PMP: _____

Name of person contacted at PMP's office: _____ Date contacted: _____

Reason PMP stated he would not authorize treatment:

I am requesting an override due to:

☐ Recipient assigned incorrectly to PMP. Please explain: _____☐ This recipient has moved.☐ Unable to contact PMP. Please explain: _____☐ Other. Please explain: _____

Provider Name: _____ Provider Number: _____

Provider Contact: _____ Telephone : () _____ Fax: () _____

Form 391

Alabama Medicaid Agency

E.25 Request for Administrative Review of Outdated Medicaid Claim

Alabama Medicaid Agency

REQUEST FOR ADMINISTRATIVE REVIEW OF OUTDATED MEDICAID CLAIM

This form is to be completed only if the claim is more than one year old as specified on the reverse side.

Section A

Print or Type	
Provider's Name	Provider Number
Recipient's Name	Recipient's Medicaid Number
Date of Service	ICN #

I do not agree with the determination you made on my claim as described on my Explanation of Payment dated:

Section B

My reasons are:

Section C

Signature of either the provider or his/her representative	
Provider Signature	Representative Signature
Address	Address
City, State and ZIP Code	City, State and ZIP Code
Telephone Number	Telephone Number
Date	Date

7.2.1 - Administrative Review and Fair Hearings **Alabama Medicaid Provider Manual**

Title XIX Medical Assistance State Plan for Alabama Medicaid provides that the Office of the Governor will be responsible for fulfillment of hearing provisions for all matters pertaining to the Medical Assistance Program under Title XIX. Agency regulations provide an opportunity for a hearing to providers aggrieved by an agency action.

For policy provisions regarding fair hearings, please refer to Chapter 3 of the *Alabama Medicaid Agency Administrative Code*.

When a denial of payment is received for an outdated claim, the provider may request an *administrative review* of the claim. A request for administrative review **must be received by the Medicaid Agency within 60 days of the time the claim became outdated**. In addition to a clean claim, the provider should send all relevant EOPs and previous correspondence with EDS or the Agency in order to demonstrate a good faith effort at submitting a timely claim. This information will be reviewed and a written reply will be sent to the provider.

In the case that the administrative review results in a denial of a timely request, the provider has the option to request a fair hearing. This written request must be received within 60 days of the administrative review denial.

In some cases, providers should not send requests for fair hearing for denied claims. An administrative review denial is the **final** administrative remedy for the following reasons:

- Recipient has exceeded yearly benefit limits.
- Recipient was not eligible for dates of service.
- Claim was received by the Agency more than 60 days after the claim became outdated.

Send requests for Administrative Review to the following address, care of the specific program area:

Administrative Review
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery AL 36103-5624

Include the program area in the address (for instance, write "Attn: System Support").

NOTE:

If all administrative remedies have been exhausted and the claim denies, the provider cannot collect from either the recipient or his/her sponsor or family.

If the Administrative Review does not result in a favorable decision, the provider may request an informal conference before proceeding to a Fair Hearing.